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THE MYTH OF MENTAL ILLNESS

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MY aim in this essay is to raise the question "Is there such a thing as mental illness?" and to argue that there is not. Since the notion of mental illness is extremely widely used nowadays, inquiry into the ways in which this term is employed would seem to be especially indicated. Mental illness, of course, is not literally a "thing"—or physical object—and hence it can "exist" only in the same sort of way in which other theoretical concepts exist. Yet, familiar theories are in the habit of posing, sooner or later —at least to those who come to believe in them —as "objective truths" (or "facts"). During certain historical periods, explanatory conceptions such as deities, witches, and microorganisms appeared not only as theories but as self-evident *causes* of a vast number of events. I submit that today mental illness is widely regarded in a somewhat similar fashion, that is, as the cause of innumerable diverse happenings. As an antidote to the complacent use of the notion of mental illness—whether as a self-evident phenomenon, theory, or cause—let us ask this question: What is meant when it is asserted that someone is mentally ill?

In what follows I shall describe briefly the main uses to which the concept of mental illness has been put. I shall argue that this notion has outlived whatever usefulness it might have had and that it now functions merely as a convenient myth.

Mental Illness as a Sign of Brain Disease

The notion of mental illness derives it main support from such phenomena as syphilis of the brain or delirious conditions—intoxications, for instance —in which persons are known to manifest various peculiarities or disorders of thinking and behavior. Correctly speaking, however, these are diseases of the brain, not of the mind. According to one school of thought, *all* so-called mental illness is of this type. The assumption is made that some neurological defect, perhaps a very subtle one, will ultimately be found for all the disorders of thinking and behavior. Many contemporary psychiatrists, physicians, and other scientists hold this view. This position implies that people *cannot* have troubles—expressed in what are *now called* "mental illnesses"—because of differences in personal needs, opinions, social aspirations, values, and so on. *All problems in living* are attributed to physicochemical processes which in due time will be discovered by medical research.

"Mental illnesses" are thus regarded as basically no different than all other diseases (that is, of the body). The only difference, in this view, between mental and bodily diseases is that the former, affecting the brain, manifest themselves by means of mental symptoms; whereas the latter, affecting other organ systems (for example, the skin, liver, etc.), manifest themselves by means of symptoms referable to those parts of the body. This view rests on and expresses what are, in my opinion, two fundamental errors.

In the first place, what central nervous system symptoms would correspond to a skin eruption or a fracture? It would *not* be some emotion or complex bit of behavior. Rather, it would be blindness or a paralysis of some part of the body. The crux of the matter is that a disease of the brain, analogous to a disease of the skin or bone, is a neurological defect, and not a problem in living. For example, a *defect* in a person's visual field may be satisfactorily explained by correlating it with certain definite lesions in the nervous system. On the other hand, a person's *belief*—whether this be a belief in Christianity, in Communism, or in the idea that his internal organs are "rotting" and that his body is, in fact, already "dead"—cannot be explained by a defect or disease of the nervous system. Explanations of this sort of occurrence—assuming that one is interested in the belief itself and does not regard it simply as a "symptom" or expression of something else that is *more interesting* —must be sought along different lines.

The second error in regarding complex psychosocial behavior, consisting of communications about ourselves and the world about us, as mere symptoms

of neurological functioning is *epistemological.* In other words, it is an error pertaining not to any mistakes in observation or reasoning, as such, but rather to the way in which we organize and express our knowledge. In the present case, the error lies in making a symmetrical dualism between mental and physical (or bodily) symptoms, a dualism which is merely a habit of speech and to which no known observations can be found to correspond. Let us see if this is so. In medical practice, when we speak of physical disturbances, we mean either signs (for example, a fever) or symptoms (for example, pain). We speak of mental symptoms, on the other hand, when we refer to a patient's *communications about himself, others, and the world about him.* He might state that he is Napoleon or that he is being persecuted by the Communists. These would be considered mental symptoms *only* if the observer believed that the patient was *not* Napoleon or that he was *not* being perseucted by the Communists. This makes it apparent that the statement that "*X* is a mental symptom" involves rendering a judgment. The judgment entails, moreover, a covert comparison or matching of the patient's ideas, concepts, or beliefs with those of the observer and the society in which they live. The notion of mental symptom is therefore inextricably tied to the *social* (including *ethical*) *context* in which it is made in much the same way as the notion of bodily symptom is tied to an *anatomical* and *genetic context* (Szasz, 1957a, 1957b).

To sum up what has been said thus far: I have tried to show that for those who regard mental symptoms as signs of brain disease, the concept of mental illness is unnecessary and misleading. For what they mean is that people so labeled suffer from diseases of the brain; and, if that is what they mean, it would seem better for the sake of clarity to say that and not something else.

MENTAL ILLNESS AS A NAME FOR PROBLEMS IN LIVING

The term "mental illness" is widely used to describe something which is very different than a disease of the brain. Many people today take it for granted that living is an arduous process. Its hardship for modern man, moreover, derives not so much from a struggle for biological survival as from the stresses and strains inherent in the social intercourse of complex human personalities. In this context, the notion of mental illness is used to identify or describe some feature of an individual's so-called personality. Mental illness—as a deformity of the personality, so to speak—is then regarded as the *cause* of the human disharmony. It is implicit in this view that social intercourse between people is regarded as something *inherently harmonious,* its disturbance being due solely to the presence of "mental illness" in many people. This is obviously fallacious reasoning, for it makes the abstraction "mental illness" into a *cause,* even though this abstraction was created in the first place to serve only as a shorthand expression for certain types of human behavior. It now becomes necessary to ask: "What kinds of behavior are regarded as indicative of mental illness, and by whom?"

The concept of illness, whether bodily or mental, implies *deviation from some clearly defined norm.* In the case of physical illness, the norm is the structural and functional integrity of the human body. Thus, although the desirability of physical health, as such, is an ethical value, what health *is* can be stated in anatomical and physiological terms. What is the norm deviation from which is regarded as mental illness? This question cannot be easily answered. But whatever this norm might be, we can be certain of only one thing: namely, that it is a norm that must be stated in terms of *psychosocial, ethical,* and *legal* concepts. For example, notions such as "excessive repression" or "acting out an unconscious impulse" illustrate the use of psychological concepts for judging (so-called) mental health and illness. The idea that chronic hostility, vengefulness, or divorce are indicative of mental illness would be illustrations of the use of ethical norms (that is, the desirability of love, kindness, and a stable marriage relationship). Finally, the widespread psychiatric opinion that only a mentally ill person would commit homicide illustrates the use of a legal concept as a norm of mental health. The norm from which deviation is measured whenever one speaks of a mental illness is a *psychosocial and ethical one.* Yet, the remedy is sought in terms of *medical* measures which—it is hoped and assumed—are free from wide differences of ethical value. The definition of the disorder and the terms in which its remedy are sought are therefore at serious odds with one another. The practical significance of this covert conflict between the alleged nature of the defect and the remedy can hardly be exaggerated.

Having identified the norms used to measure

deviations in cases of mental illness, we will now turn to the question: "Who defines the norms and hence the deviation?" Two basic answers may be offered: (*a*) It may be the person himself (that is, the patient) who decides that he deviates from a norm. For example, an artist may believe that he suffers from a work inhibition; and he may implement this conclusion by seeking help *for* himself from a psychotherapist. (*b*) It may be someone other than the patient who decides that the latter is deviant (for example, relatives, physicians, legal authorities, society generally, etc.). In such a case a psychiatrist may be hired by others to do something *to* the patient in order to correct the deviation.

These considerations underscore the importance of asking the question "Whose agent is the psychiatrist?" and of giving a candid answer to it (Szasz, 1956, 1958). The psychiatrist (psychologist or nonmedical psychotherapist), it now develops, may be the agent of the patient, of the relatives, of the school, of the military services, of a business organization, of a court of law, and so forth. In speaking of the psychiatrist as the agent of these persons or organizations, it is not implied that his values concerning norms, or his ideas and aims concerning the proper nature of remedial action, need to coincide exactly with those of his employer. For example, a patient in individual psychotherapy may believe that his salvation lies in a new marriage; his psychotherapist need not share this hypothesis. As the patient's agent, however, he must abstain from bringing social or legal force to bear on the patient which would prevent him from putting his beliefs into action. If his *contract* is with the patient, the psychiatrist (psychotherapist) may disagree with him or stop his treatment; but he cannot engage others to obstruct the patient's aspirations. Similarly, if a psychiatrist is engaged by a court to determine the sanity of a criminal, he need not fully share the legal authorities' values and intentions in regard to the criminal and the means available for dealing with him. But the psychiatrist is expressly barred from stating, for example, that it is not the criminal who is "insane" but the men who wrote the law on the basis of which the very actions that are being judged are regarded as "criminal." Such an opinion could be voiced, of course, but not in a courtroom, and not by a psychiatrist who makes it his practice to assist the court in performing its daily work.

To recapitulate: In actual contemporary social usage, the finding of a mental illness is made by establishing a deviance in behavior from certain psychosocial, ethical, or legal norms. The judgment may be made, as in medicine, by the patient, the physician (psychiatrist), or others. Remedial action, finally, tends to be sought in a therapeutic —or covertly medical—framework, thus creating a situation in which *psychosocial, ethical,* and/or *legal deviations* are claimed to be correctible by (so-called) *medical action.* Since medical action is designed to correct only medical deviations, it seems logically absurd to expect that it will help solve problems whose very existence had been defined and established on nonmedical grounds. I think that these considerations may be fruitfully applied to the present use of tranquilizers and, more generally, to what might be expected of drugs of whatever type in regard to the amelioration or solution of problems in human living.

THE ROLE OF ETHICS IN PSYCHIATRY

Anything that people *do*—in contrast to things that *happen* to them (Peters, 1958)—takes place in a context of value. In this broad sense, no human activity is devoid of ethical implications. When the values underlying certain activities are widely shared, those who participate in their pursuit may lose sight of them altogether. The discipline of medicine, both as a pure science (for example, research) and as a technology (for example, therapy), contains many ethical considerations and judgments. Unfortunately, these are often denied, minimized, or merely kept out of focus; for the ideal of the medical profession as well as of the people whom it serves seems to be having a system of medicine (allegedly) free of ethical value. This sentimental notion is expressed by such things as the doctor's willingness to treat and help patients irrespective of their religious or political beliefs, whether they are rich or poor, etc. While there may be some grounds for this belief—albeit it is a view that is not impressively true even in these regards—the fact remains that ethical considerations encompass a vast range of human affairs. By making the practice of medicine neutral in regard to some specific issues of value need not, and cannot, mean that it can be kept free from all such values. The practice of medicine is intimately tied to ethics; and the first thing that we must do, it seems to me, is to try to make this clear and explicit. I shall

let this matter rest here, for it does not concern us specifically in this essay. Lest there be any vagueness, however, about how or where ethics and medicine meet, let me remind the reader of such issues as birth control, abortion, suicide, and euthanasia as only a few of the major areas of current ethicomedical controversy.

Psychiatry, I submit, is very much more intimately tied to problems of ethics than is medicine. I use the word "psychiatry" here to refer to that contemporary discipline which is concerned with *problems in living* (and not with diseases of the brain, which are problems for neurology). Problems in human relations can be analyzed, interpreted, and given meaning only within given social and ethical contexts. Accordingly, it *does* make a difference—arguments to the contrary notwithstanding—what the psychiatrist's socioethical orientations happen to be; for these will influence his ideas on what is wrong with the patient, what deserves comment or interpretation, in what possible directions change might be desirable, and so forth. Even in medicine proper, these factors play a role, as for instance, in the divergent orientations which physicians, depending on their religious affiliations, have toward such things as birth control and therapeutic abortion. Can anyone really believe that a psychotherapist's ideas concerning religious belief, slavery, or other similar issues play no role in his practical work? If they do make a difference, what are we to infer from it? Does it not seem reasonable that we ought to have different psychiatric therapies—each expressly recognized for the ethical positions which they embody—for, say, Catholics and Jews, religious persons and agnostics, democrats and communists, white supremacists and Negroes, and so on? Indeed, if we look at how psychiatry is actually practiced today (especially in the United States), we find that people do seek psychiatric help in accordance with their social status and ethical beliefs (Hollingshead & Redlich, 1958). This should really not surprise us more than being told that practicing Catholics rarely frequent birth control clinics.

The foregoing position which holds that contemporary psychotherapists deal with problems in living, rather than with mental illnesses and their cures, stands in opposition to a currently prevalent claim, according to which mental illness is just as "real" and "objective" as bodily illness. This is a confusing claim since it is never known exactly what is meant by such words as "real" and "objective." I suspect, however, that what is intended by the proponents of this view is to create the idea in the popular mind that mental illness is some sort of disease entity, like an infection or a malignancy. If this were true, one could *catch* or *get* a "mental illness," one might *have* or *harbor* it, one might *transmit* it to others, and finally one could get *rid* of it. In my opinion, there is not a shred of evidence to support this idea. To the contrary, all the evidence is the other way and supports the view that what people now call mental illnesses are for the most part *communications* expressing unacceptable ideas, often framed, moreover, in an unusual idiom. The scope of this essay allows me to do no more than mention this alternative theoretical approach to this problem (Szasz, 1957c).

This is not the place to consider in detail the similarities and differences between bodily and mental illnesses. It shall suffice for us here to emphasize only one important difference between them: namely, that whereas bodily disease refers to public, physicochemical occurrences, the notion of mental illness is used to codify relatively more private, sociopsychological happenings of which the observer (diagnostician) forms a part. In other words, the psychiatrist does not stand *apart* from what he observes, but is, in Harry Stack Sullivan's apt words, a "participant observer." This means that he is *committed* to some picture of what he considers reality—and to what he thinks society considers reality—and he observes and judges the patient's behavior in the light of these considerations. This touches on our earlier observation that the notion of mental symptom itself implies a comparison between observer and observed, psychiatrist and patient. This is so obvious that I may be charged with belaboring trivialities. Let me therefore say once more that my aim in presenting this argument was expressly to criticize and counter a prevailing contemporary tendency to deny the moral aspects of psychiatry (and psychotherapy) and to substitute for them allegedly value-free medical considerations. Psychotherapy, for example, is being widely practiced as though it entailed nothing other than restoring the patient from a state of mental sickness to one of mental health. While it is generally accepted that mental illness has something to do with man's social (or interpersonal) relations, it is paradoxically maintained that problems of values (that is, of ethics) do not

arise in this process.[1] Yet, in one sense, much of psychotherapy may revolve around nothing other than the elucidation and weighing of goals and values—many of which may be mutually contradictory—and the means whereby they might best be harmonized, realized, or relinquished.

The diversity of human values and the methods by means of which they may be realized is so vast, and many of them remain so unacknowledged, that they cannot fail but lead to conflicts in human relations. Indeed, to say that human relations at all levels—from mother to child, through husband and wife, to nation and nation—are fraught with stress, strain, and disharmony is, once again, making the obvious explicit. Yet, what may be obvious may be also poorly understood. This I think is the case here. For it seems to me that—at least in our scientific theories of behavior—we have failed to *accept* the simple fact that human relations are inherently fraught with difficulties and that to make them even relatively harmonious requires much patience and hard work. I submit that the idea of mental illness is now being put to work to obscure certain difficulties which at present may be inherent—not that they need be unmodifiable—in the social intercourse of persons. If this is true, the concept functions as a disguise; for instead of calling attention to conflicting human needs, aspirations, and values, the notion of mental illness provides an amoral and impersonal "thing" (an "illness") as an explanation for *problems in living* (Szasz, 1959). We may recall in this connection that not so long ago it was devils and witches who were held responsible for men's problems in social living. The belief in mental illness, as something other than man's trouble in getting along with his fellow man, is the proper heir to the belief in demonology and witchcraft. Mental illness exists or is "real" in exactly the same sense in which witches existed or were "real."

[1] Freud went so far as to say that: "I consider ethics to be taken for granted. Actually I have never done a mean thing" (Jones, 1957, p. 247). This surely is a strange thing to say for someone who has studied man as a social being as closely as did Freud. I mention it here to show how the notion of "illness" (in the case of psychoanalysis, "psychopathology," or "mental illness") was used by Freud—and by most of his followers—as a means for classifying certain forms of human behavior as falling within the scope of medicine, and hence (by *fiat*) outside that of ethics!

CHOICE, RESPONSIBILITY, AND PSYCHIATRY

While I have argued that mental illnesses do not exist, I obviously did not imply that the social and psychological occurrences to which this label is currently being attached also do not exist. Like the personal and social troubles which people had in the Middle Ages, they are real enough. It is the labels we give them that concerns us and, having labelled them, what we do about them. While I cannot go into the ramified implications of this problem here, it is worth noting that a demonologic conception of problems in living gave rise to therapy along theological lines. Today, a belief in mental illness implies—nay, requires—therapy along medical or psychotherapeutic lines.

What is implied in the line of thought set forth here is something quite different. I do not intend to offer a new conception of "psychiatric illness" nor a new form of "therapy." My aim is more modest and yet also more ambitious. It is to suggest that the phenomena now called mental illnesses be looked at afresh and more simply, that they be removed from the category of illnesses, and that they be regarded as the expressions of man's struggle with the problem of *how* he should live. The last mentioned problem is obviously a vast one, its enormity reflecting not only man's inability to cope with his environment, but even more his increasing self-reflectiveness.

By problems in living, then, I refer to that truly explosive chain reaction which began with man's fall from divine grace by partaking of the fruit of the tree of knowledge. Man's awareness of himself and of the world about him seems to be a steadily expanding one, bringing in its wake an ever larger *burden of understanding* (an expression borrowed from Susanne Langer, 1953). *This burden,* then, *is to be expected and must not be misinterpreted.* Our only *rational* means for lightening it is *more understanding,* and appropriate *action* based on such understanding. The main alternative lies in acting as though the burden were not what in fact we perceive it to be and taking refuge in an outmoded theological view of man. In the latter view, man does not fashion his life and much of his world about him, but merely lives out his fate in a world created by superior beings. This may logically lead to pleading nonresponsibility in the face of seemingly unfathomable problems and difficulties. Yet, if man fails to take increasing responsibility for his

actions, individually as well as collectively, it seems unlikely that some higher power or being would assume this task and carry this burden for him. Moreover, this seems hardly the proper time in human history for obscuring the issue of man's responsibility for his actions by hiding it behind the skirt of an all-explaining conception of mental illness.

CONCLUSIONS

I have tried to show that the notion of mental illness has outlived whatever usefulness it might have had and that it now functions merely as a convenient myth. As such, it is a true heir to religious myths in general, and to the belief in witchcraft in particular; the role of all these belief-systems was to act as *social tranquilizers,* thus encouraging the hope that mastery of certain specific problems may be achieved by means of substitutive (symbolic-magical) operations. The notion of mental illness thus serves mainly to obscure the everyday fact that life for most people is a continuous struggle, not for biological survival, but for a "place in the sun," "peace of mind," or some other human value. For man aware of himself and of the world about him, once the needs for preserving the body (and perhaps the race) are more or less satisfied, the problem arises as to what he should do with himself. Sustained adherence to the myth of mental illness allows people to avoid facing this problem, believing that mental health, conceived as the absence of mental illness, automatically insures the making of right and safe choices in one's conduct of life. But the facts are all the other way. It is the making of good choices in life that others regard, retrospectively, as good mental health!

The myth of mental illness encourages us, moreover, to believe in its logical corollary: that social intercourse would be harmonious, satisfying, and the secure basis of a "good life" were it not for the disrupting influences of mental illness or "psychopathology." The potentiality for universal human happiness, in this form at least, seems to me but another example of the I-wish-it-were-true type of fantasy. I do believe that human happiness or well-being on a hitherto unimaginably large scale, and not just for a select few, is possible. This goal could be achieved, however, only at the cost of many men, and not just a few being willing and able to tackle their personal, social, and ethical conflicts. This means having the courage and integrity to forego waging battles on false fronts, finding solutions for substitute problems—for instance, fighting the battle of stomach acid and chronic fatigue instead of facing up to a marital conflict.

Our adversaries are not demons, witches, fate, or mental illness. We have no enemy whom we can fight, exorcise, or dispel by "cure." What we do have are *problems in living*—whether these be biologic, economic, political, or sociopsychological. In this essay I was concerned only with problems belonging in the last mentioned category, and within this group mainly with those pertaining to moral values. The field to which modern psychiatry addresses itself is vast, and I made no effort to encompass it all. My argument was limited to the proposition that mental illness is a myth, whose function it is to disguise and thus render more palatable the bitter pill of moral conflicts in human relations.

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